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The right of everyone to enjoy the highest attainable standard of physical and mental health

Note by the Secretary-General*

The Secretary-General has the honour to transmit to the Members of the General Assembly the report of Paul Hunt, Special Rapporteur of the Commission on Human Rights, in accordance with Economic and Social Council resolution 2003/45.

* The present report is submitted late so as to include as much up-to-date information as possible.

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Interim report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to enjoy the highest attainable standard of physical and mental health, Mr. Paul Hunt

Summary

The present report reflects on the activities of, and issues of particular interest to, the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health in the period since his preliminary report to the Commission on Human Rights (E/CN.4/2002/58). In section II, the Special Rapporteur suggests that right to health indicators can help States recognize when policy adjustments may be required. He argues that some right to health indicators may help a State monitor the progressive realization of the right to health in its jurisdiction, while others may help to monitor the exercise of international responsibilities that extend beyond a State's borders and impact on health in other jurisdictions. As requested by the Commission, section III provides an introductory overview of some of the conceptual and other issues arising from right to health good practices. In section IV, the Special Rapporteur expresses his concern about the continuing obstacles to ensuring access to prevention and treatment for HIV/AIDS, and suggests that one of the most distinctive contributions that human rights bring to the struggle against the HIV/AIDS pandemic is enhanced accountability. Section V briefly highlights the need to address the right to health implications of neglected diseases and suggests that it might be timely to devise a right to health approach to the elimination of leprosy. Finally, as requested by the Commission, the Special Rapporteur comments on the proposal for an optional protocol to the International Covenant on Economic, Social and Cultural Rights.

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I. Introduction

1. The mandate of the Special Rapporteur is contained in Commission on Human Rights resolution 2002/31. The Special Rapporteur, Paul Hunt (New Zealand) submitted his preliminary report (E/CN.4/2003/58) to the Commission at its fifty-ninth session. In its resolution 2003/28, the Commission invited him, inter alia, to submit annually an interim report to the General Assembly on the activities performed under his mandate. The present report is submitted in accordance with that request.

2. Since submitting his preliminary report, the Special Rapporteur has continued to consult, and develop cooperation with, States as well as intergovernmental and non-governmental organizations.[1] In July and August 2003, the Special Rapporteur undertook a mission to the World Trade Organization (WTO) in order to pursue his interest in monitoring and examining trade rules and policies in the context of the right to health. He held meetings with the WTO secretariat, chairpersons of relevant councils, and WTO members and observers. In connection with the mission, he also met with experts from the World Intellectual Property Organization (WIPO), WHO and several NGOs. He is grateful to all those whom he met, and for the support extended by the Director General of WTO, and the late High Commissioner for Human Rights, in relation to the mission. A report on his mission will be submitted to the Commission at its sixtieth session along with an annual report with details of other activities performed under his mandate.

3. Every year more than 10 million children die of preventable illness — 30,000 a day. More than 500,000 women a year die in pregnancy and childbirth. Such deaths are 100 times more likely in sub-Saharan Africa than in the high-income countries of the Organisation for Economic Cooperation and Development (OECD). Forty-two million people are living with HIV/AIDS, 39 million of them in developing countries. Tuberculosis causes 2 million deaths a year. Malaria deaths, now 1 million a year, could double in the next 20 years. Leprosy continues to stigmatize tens of millions. More than 1 billion people — one person in five — lack access to safe water. Safe water and adequate sanitation are matters of life and death — diarrhoea is a major killer of young children: in the 1990s alone it killed more children than all the people lost to armed conflict since 1945.[2] Ten per cent of health research and development spending is directed at the health problems of 90 per cent of the world's population.

4. Much of this interim report addresses conceptual issues that seem far removed from these alarming facts. For example, it considers what constitutes a right to health indicator and the criteria for identifying a right to health good practice. Conceptual work of this sort is valuable — provided that, in due course, it leads to improvements in health status and greater respect for the fundamental human right to health, especially of those living in poverty. The Special Rapporteur welcomes the views of Member States on any issue arising from either this report or his mandate generally and, in particular, on the following issues:

(a) Are right to health indicators useful tools to help a State monitor the progressive realization of the right to health in its jurisdiction? Are they also useful tools for monitoring the exercise of those international responsibilities that (i) extend beyond a State's borders and (ii) bear upon health? (see paras 5- 37);

(b) If the Special Rapporteur is to collect examples of right to health good practices, how should he distinguish a right to health good practice from a health good practice? (see paras. 38-62);

(c) What is the distinctive contribution of the Special Rapporteur in the context of HIV/AIDS? (see paras. 64-75);

(d) Health research is vital to the promotion of good health, development and poverty reduction, yet only about 10 per cent of health research and development spending is directed at 90 per cent of the world's health problems. How should this serious human rights and humanitarian issue be addressed? (see paras. 76-80).

II. Right to health indicators: an incremental approach

5. In paragraph 33 of his preliminary report, the Special Rapporteur remarked that he wished to explore various analytical frameworks and tools that deepen understanding of the right to health. He identified three frameworks or tools of particular interest, the third being right to health indicators and benchmarks:

> "Third, [the Committee on Economic, Social and Cultural Rights] signals the importance of indicators and benchmarks [see paras. 57-58 of general comment No. 14]. The international right to health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring its progress, a State needs a device to measure this variable dimension of the right to health. [The Committee] suggests that the most appropriate device is the combined application of national right to health indicators and benchmarks. Thus, a State selects appropriate right to health indicators that will help it monitor different dimensions of the right to health. Each indicator will require disaggregation on the prohibited grounds of discrimination. Then the State sets appropriate national targets — or benchmarks — in relation to each disaggregated indicator. It may use these national indicators and benchmarks to monitor its progress over time, enabling it to recognize when policy adjustments are required. Of course, no matter how sophisticated they might be, right to health indicators and benchmarks will never give a complete picture of the enjoyment of the right to health in a specific jurisdiction. At best, they provide useful background indications regarding the right to health in a particular national context."

6. Since his preliminary report, the Special Rapporteur has attended a workshop on right to health indicators organized by WHO. Drawing on that meeting and other consultations, the Special Rapporteur, in the following paragraphs, elaborates further his general approach to right to health indicators. He invites comments and suggestions from all parties on this general approach. The Special Rapporteur intends to devote continuing attention to right to health indicators, with a view to developing gradually a practical, realistic and balanced approach.

What are the roles for human rights indicators?

7. The United Nations Development Programme (UNDP) *Human Development Report 2000: Human Rights and Human Development*, devotes a chapter to, and makes a compelling case for, the careful use of human rights indicators: "Statistical

indicators are a powerful tool in the struggle for human rights. They make it possible for people and organizations — from grass-roots activists and civil society to governments and the United Nations — to identify important actors and hold them accountable for their actions."[3] Indicators, it continues, can be used as tools for:

- Making better policies and monitoring progress;
- Identifying unintended impacts of laws, policies and practices;
- Identifying which actors are having an impact on the realization of rights;
- Revealing whether the obligations of these actors are being met;
- Giving early warning of potential violations, prompting preventive action;
- Enhancing social consensus on difficult trade-offs to be made in the face of resource constraints;
- Exposing issues that had been neglected or silenced.[4]

Crucially, human rights indicators can help States, and others, recognize when national and international policy adjustments are required.

Is there a difference between a health indicator and a right to health indicator?

8. Health professionals and policy makers constantly use a wide array of health indicators. Is it possible to simply appropriate these health indicators and use them in the context of human rights? Or do right to health indicators have special features that distinguish them from health indicators? If so, what are these distinctive features of right to health indicators?

9. In recent years, these important unanswered questions have impeded the development of right to health indicators. The Special Rapporteur suggests it is time to provide preliminary answers to these difficult questions. The following preliminary response might need refining in the future, but it is offered with the objective of enabling the discussion about right to health indicators to progress.

10. The Special Rapporteur suggests that a right to health indicator derives from, reflects and is designed to monitor the realization or otherwise of specific right to health norms, usually with a view to holding a duty bearer to account (see E/CN.4/2003/58, paras. 10-36). Thus, what tends to distinguish a right to health indicator from a health indicator is less its substance than (i) its explicit derivation from specific right to health norms; and (ii) the purpose to which it is put, namely right to health monitoring with a view to holding duty-bearers to account.[5]

11. For the time being, this preliminary response requires three additional comments. First, while it is suggested that a health indicator may be regarded as a right to health indicator if it corresponds to a specific right to health norm, this correspondence — or link — has to be reasonably exact. For example, it is unconvincing to argue that a health indicator is a right to health indicator because it somehow reflects "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". In that example, the norm is exceedingly vague and the correspondence between indicator and norm will inevitably be inexact. The relationship between indicator and norm has to be reasonably close and precise.

12. Second, the right to health cannot be viewed in isolation: it is closely related to the enjoyment of other human rights and fundamental freedoms, including non-discrimination and equality — two concepts that reflect the pre-occupation of human rights with vulnerable and disadvantaged groups. Just as the right to health has to be seen in this broader normative context, so do right to health indicators. Accordingly, right to health indicators should not only reflect specific right to health norms, but also related human rights provisions, including non-discrimination and equality. For example, while a health indicator might or might not be disaggregated, many right to health indicators will have to be disaggregated, otherwise they will fail to reflect a vital feature of the right to health.

13. Third, for its part, the human rights community must acknowledge that the collection of disaggregated data remains an enormous challenge for many States. Because of limited capacity, reliable disaggregated data is often unavailable. Nonetheless, as a point of departure, the goal should be to use, where relevant, right to health indicators that are disaggregated in relation to as many of the internationally prohibited grounds of discrimination as possible.[6]

Three categories of right to health indicators

14. The literature reveals a multitude of health indicators. But there is a more fundamental difficulty. So far as the Special Rapporteur is aware, there is no commonly agreed and consistent way of categorizing and labelling different types of health indicators. For example, the following categories and labels for indicators can be found: performance, statistical, variable, process, conduct, outcome, output, result, achievement, structural, screening, qualitative, quantitative, core and rated. The same indicator may appear in several categories. The lack of a common approach to the classification of health indicators represents a challenge to those who wish to introduce a simple, consistent and rational system for right to health indicators.

15. If the discussion about right to health indicators is to progress, there must be a degree of terminological clarity and consistency. The Special Rapporteur suggests that, to begin with, special attention is devoted to the following categories of right to health indicators: structural indicators, process indicators and outcome indicators. While there is no unanimity in the health literature, these categories and labels appear to be widely understood — for example, they are the terms routinely used by the WHO Department of Essential Drugs and Medicines Policy.[7] The Special Rapporteur accepts that, in due course, it might be necessary to look at other categories of indicators. Moreover, these categories themselves might need to be refined in the light of experience. But, so as to advance the discussion, he proposes to begin by giving particular attention to these three categories of indicators, as described in the following paragraphs.

16. The Special Rapporteur is pleased to report that Eibe Riedel, Vice-Chair of the Committee on Economic, Social and Cultural Rights (CESCR), has agreed to use the terms structural, process and outcome indicators, as described below, when discussing right to health indicators. Significantly, this agreement should lead to the development of consistent approaches, by the Special Rapporteur and the Committee, to right to health indicators. Such consistency will simplify the work of States, intergovernmental organizations, civil society groups and others, insofar as it

relates to right to health indicators. The Special Rapporteur is most grateful to the Vice-Chair for his support in this endeavour.

17. The following discussion does not attempt to identify specific right to health indicators. It has a more modest ambition: to identify some basic categories and labels for right to health indicators. A later exercise will be to identify specific right to health indicators using the approach set out below.

Structural indicators

18. Structural indicators are among the simplest type of indicators. They are usually framed as a question and often generate a simple yes/no answer. The answer to the question usually depends on information that is easily available. In other words, structural indicators offer a rapid-assessment and cost-effective reporting methodology based on a questionnaire. As already indicated, the WHO Department of Essential Drugs and Medicines Policy routinely uses the label "structural indicators" and this questionnaire methodology.

19. Broadly speaking, structural indicators address whether or not key structures, systems and mechanisms are in place in relation to a particular issue. Thus, a right to health structural indicator would address whether or not key structures, systems and mechanisms that are considered necessary for, or conducive to, the realization of the right to health are in place.

20. By way of illustration, examples of structural indicators, taken from general law and policy, sexual and reproductive health, and essential medicines, include the following:

- Does the State constitutionalize the right to health?
- Does the State have a national human rights institution the mandate of which includes the right to health?
- Has the Government adopted a national strategy and plan of action to reduce maternal mortality?
- Does the Government have an Essential Medicines List?
- Which medicines are free of charge at primary public health facilities:
  - All medicines?
  - Malaria medicines?
  - HIV/AIDS-related medicines?
  - Are all medicines free for under-fives/pregnant women/elderly persons/all who cannot afford them?
  - Are no medicines free?
- Have compulsory licensing provisions for pharmaceuticals been incorporated into national legislation?

21. These illustrations suggest both the utility and limitations of structural indicators. For instance, the answer to the first question might be "yes" — and this is a useful piece of information. But if a constitutionalized right to health neither generates any successful litigation nor is taken into account in national policy-

making processes, it is of very restricted value. In other words, structural indicators — like all indicators — are useful, but have their limitations. The usefulness of structural indicators is enhanced if they are employed with process and outcome indicators.

Process indicators, outcome indicators

General remarks

22. Process and outcome indicators can be designed to help a State monitor the variable dimension of the right to health that arises from the concept of progressive realization. (It is for this reason that they are sometimes referred to as variable indicators.) These are the indicators referred to by the Special Rapporteur in his preliminary report, the relevant passage from which is replicated in paragraph 5 above. They are also the indicators signalled by CESCR in general comments Nos. 14 (right to health) and 15 (right to water).[8] Their key feature is that they can be used to monitor change over time.

23. Significantly, while CESCR has affirmed the utility of process and outcome indicators, it has not yet identified specific right to health process and outcome indicators. This is a challenge for the future.

24. Alone, process and outcome indicators tell us very little. As general comments Nos. 14 and 15 explain, they become a helpful tool when used with benchmarks or targets. When process and outcome indicators are combined with benchmarks, they become a useful device for monitoring health over time. Thus, the under-five mortality rate is an outcome indicator — and the target of reducing under-five mortality by (say) 10 per cent in two years is a benchmark or target. The under-five mortality rate indicator alone, without some past, present or future benchmark, is uninformative. Many process and outcome indicators (and therefore their benchmarks, too) should be disaggregated on the prohibited grounds of discrimination.

25. There are important differences between structural indicators, on the one hand, and process and outcome indicators on the other. While a structural indicator does not usually need a benchmark (it usually permits only a yes/no answer), process and outcome indicators depend upon benchmarks or targets that usually consist of a percentage or number. Also, while a structural indicator may depend upon a simple questionnaire, process and outcome indicators may require a more sophisticated form of survey.

Process indicators

26. Process indicators provide information on the processes by which a health policy is implemented. They measure the degree to which activities that are necessary to attain certain health objectives are carried out, and the progress of those activities over time. They monitor, as it were, effort, not outcome.

27. By way of illustration, examples of process indicators, taken from sexual and reproductive health, and HIV/AIDS, include the following:[9]

- Percentage of women attended at least once during pregnancy by skilled health personnel for reasons relating to pregnancy;

- Percentage of births attended by skilled health personnel;
- Number of facilities with functioning basic essential obstetric care per 500,000 population;
- Percentage of people with advanced HIV infection receiving antiretroviral combination therapy.

Outcome indicators

28. Outcome indicators measure the results achieved by health-related policies. They show the "facts" about people's health, such as maternal mortality, prevalence of HIV, prevalence of rape, and so on. Outcome indicators usually reflect many interrelated processes that collectively determine an outcome, e.g. maternal mortality — an outcome indicator — is influenced by various processes, including maternal health care, sanitation and education. Many Millennium Development Goal indicators are outcome indicators.

29. By way of illustration, examples of outcome indicators, also taken from sexual and reproductive health, and HIV/AIDS, include the following:[10]

- The number of maternal deaths per 100,000 live births;
- The number of perinatal deaths per 1,000 births;
- Percentage of women who have undergone female genital mutilation;
- Percentage of young people (15-24 years) who are infected with HIV.

Right to health indicators for the national and international levels

30. The main focus of international human rights law is directed to the acts and omissions of States within their own jurisdictions. Naturally, therefore, discussions about human rights indicators tend to have the same orientation. Indeed, the illustrative indicators mentioned in the preceding paragraphs focus on the national level.

31. However, as the Special Rapporteur noted in his preliminary report, international human rights also place responsibilities on States in relation to their conduct beyond their own jurisdictions — consider the references to international assistance and cooperation, and similar formulations, in the Universal Declaration of Human Rights, as well as in binding human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. Moreover, the outcomes of recent world conferences include passages that resonate with the international assistance and cooperation provisions of international human rights law. In the Millennium Declaration, for example, 147 heads of State and Government — 191 nations in total — recognize that "in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level" (para. 2). The Millennium Declaration repeatedly affirms the twin principles of shared responsibility and global equity, principles that also animate the human rights concept of international assistance and cooperation.

32. In this context, the Special Rapporteur makes two general observations. First, international assistance and cooperation should not be understood as encompassing only financial and technical assistance: it also includes a responsibility to work

actively towards equitable multilateral trading, investment and financial systems that are conducive to the reduction and elimination of poverty. Second, while lawyers may debate the legal nature and scope of international assistance and cooperation under international human rights law, nobody can seriously dispute that States have, to one degree or another, international human rights responsibilities that extend beyond their own borders.

33. In these circumstances, human rights indicators are needed to monitor the discharge of a State's human rights responsibilities that extend beyond its borders. The international community has already begun to identify indicators that monitor these responsibilities. For example, a number of indicators have been identified in relation to Millennium Development Goal 8, one of them being the amount of a donor's official development assistance as a percentage of its gross national product. In 2001, the General Assembly, at its special session on HIV/AIDS, adopted the Declaration of Commitment on HIV/AIDS "Global Crisis — Global Action" (resolution S-26/2) and, in the following year, the Programme Coordinating Board of UNAIDS approved a set of core indicators for implementation of the Declaration of Commitment.[11] Five of these core indicators relate to the global level. One indicator is the amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition; another is the percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes. The Special Rapporteur is not arguing here that these are human rights indicators, but that they provide a precedent for the formulation of human rights indicators at the international level.

34. The crucial point is that any attempt to identify right to health indicators must encompass the responsibilities of States at both the national and international levels. For his part, the Special Rapporteur proposes to identify, in his forthcoming work, possible right to health indicators at both levels.

Conclusion

35. This section has sought to clarify, and invites comments on. the basic concepts and terminology that the Special Rapporteur proposes to employ in his future work on right to health indicators. To facilitate understanding he has provided examples of structural, process and outcome indicators in the context of health. However, with the exception of the first two structural indicators (see para. 20), the examples of health indicators set out in this section are not necessarily right to health indicators. Whether they are or not will be the subject of separate inquiry in forthcoming reports.

36. Subject to his resources and any comments he may receive on the approach outlined in this section, the Special Rapporteur aims to apply this approach to one or two health specializations, such as essential medicines, sexual and reproductive health, HIV/AIDS, children's health, and water and sanitation. In this way, collaborating with other key actors, the Special Rapporteur hopes gradually to develop a manageable set of right to health indicators that will assist States, as well as others committed to the better implementation of the international right to health.

37. The Special Rapporteur wishes to emphasize a point made in his preliminary report. It would be foolhardy to expect too much from right to health indicators. No matter how sophisticated they might be, right to health indicators will give a complete picture of neither the enjoyment of the right to health in a specific

jurisdiction nor the State's conformity or otherwise with its international right to health obligations. Nonetheless, if carefully used, right to health indicators can help States, and others, monitor and measure the progressive realization of the international right to health.

III. Good practices for the right to health: a preliminary overview

38. In resolution 2003/28, the Commission on Human Rights invited the Special Rapporteur to give particular attention to the identification of best practices for the effective operationalization of the right to health (para. 15). This section of his interim report is a preliminary response to this invitation, based upon an initial review of the literature and informal consultations with experts from intergovernmental and non-governmental organizations, as well as academics specializing in the health and human rights field. The Special Rapporteur hopes to extend and deepen these preliminary consultations in the future.

39. In some quarters, there appears to be a movement away from the term "best practice" towards the more modest "good practice" — see, for example, the work of the United Nations Inter-Agency Committee on Women and Gender Equality. While discussion about best practices and the right to health is at such an embryonic stage, the Special Rapporteur proposes to use the more inclusive term "good practice".

40. There is an extensive literature on best and good practices in numerous fields, including some with health and human rights dimensions. However, the Special Rapporteur has not yet found literature on best or good practices in relation to the right to health. Thus, the following introductory remarks are intended to begin a public discussion about good practices and the right to health. First, they signal some of the key conceptual issues, including possible criteria for deciding what is a right to health good practice. Second, they outline a possible taxonomy — or way of classifying — right to health good practices. Third, they provide some actual initiatives that may constitute right to health good practices — or contain elements of right to health good practices.

41. Of course, until the criteria for deciding what is a right to health good practice are settled, it can be argued that it is premature to consider possible right to health good practices. However, because the parameters of this topic are not widely understood, the Special Rapporteur has formed the view that there is merit in having, at the outset, an introductory overview of the general topic, even if this overview is subject to important qualifications. On the basis of this general overview, preliminary decisions can be made about how to take the issue forward.

Some conceptual issues

42. It is necessary to develop a general methodology for understanding and utilizing good practices. For example, a good practice in one context might not work in another. If the concept of a good practice is to be a useful tool, it would be helpful to identify the specific circumstances that make a good practice transferable to another national or cultural setting. These methodological issues may seem far removed from the practical task in hand — namely to identify good practices that

help individuals and communities — but in the long run they may enhance effectiveness.[12]

43. How should good practices, in general, be defined? While there are numerous definitions, none finds universal favour. A simple working definition is an initiative, elements of which are transferable, that is more effective than other initiatives with the same objective. Different criteria are applied by different organizations to assess whether or not an initiative qualifies as a good or best practice. For example, in the context of poverty and social exclusion, the United Nations Educational, Scientific and Cultural Organization (UNESCO) describes best practices as having four features: they are innovative; make a positive difference; have a sustainable effect; and have the potential to be replicated and to serve as a model for generating initiatives elsewhere.

44. Whatever the methodology, definition and criteria of good practices in general, they then have to be applied specifically to the right to health. Thus, a working definition of a right to health good practice is an initiative, elements of which are transferable, that is more effective than other initiatives for the realization of the right to health. This leads to the question of what is the difference between a good practice in relation to health and a good practice in relation to the right to health? In other words, are all health good practices also right to health good practices? If not, what are the criteria for a right to health good practice?

45. For the purposes of discussion, the Special Rapporteur suggests that for a health good practice to be considered as a right to health good practice it must have three special features:

(a) It demonstrably enhances an individual's or group's enjoyment of one or more elements of the right to health, e.g. by improving access to essential medicines, enhancing the quality of the workplace environment, reducing discriminatory health practices, improving the participation of the poor in health policy-making, strengthening right to health accountability mechanisms, etc.;

(b) It pays particular attention to vulnerable groups, including those living in poverty;

(c) In process and outcome, the good practice is consistent with the enjoyment of all human rights.

46. The Special Rapporteur will especially appreciate comments on the adequacy of these criteria. Are additional features needed? For example, is another criterion for a right to health good practice the explicit and prior recognition, by those responsible, that the health initiative reflects, or in some way corresponds to, the right to health?

47. To take a second example, is another criterion that, in a country where minimum essential levels of the right to health have not yet been realized, the initiative contributes to the realization of one or more aspects of these minimum essential levels? If this were added as a criterion for a right to health good practice, the installation of an expensive urban specialist health facility in a country where the majority rural communities do not enjoy access to primary health care, would be ineligible for consideration as a good practice.

48. To take a third example, are some elements of the right to health (e.g. non-discrimination, participation and accountability) so fundamental that, for a health

good practice to qualify as a right to health good practice, it must always enhance these fundamental elements? If so, which elements of the right to health are to be considered fundamental?

Towards a taxonomy of right to health good practices

49. Once agreed, the criteria can then be applied to various initiatives to see whether or not they can properly be regarded as right to health good practices. There are innumerable examples of health good practices and it is likely that numerous examples of right to health good practices at the community, national and international levels will also emerge. This raises the issue of how to classify or categorize these right to health good practices. It is unhelpful to place together all right to health good practices in one large undifferentiated group. In short, a simple taxonomy of right to health good practices is needed. This will have a number of benefits, one being that an effective taxonomy will reveal in which areas there is a paucity of good practices and thus where those committed to the right to health might most usefully direct their attention with a view to developing initiatives that are especially needed.

50. A right to health taxonomy can be organized in various ways, such as by type of actor (e.g. legislature, courts, national human rights institution, private sector, international organization, donor State, etc.), area of intervention (e.g. essential drugs, sexual and reproductive health, water and sanitation, etc.), right to health normative framework, or by any combination of these. At present, the Special Rapporteur takes the view that the taxonomy should be based upon the normative framework provided by the right to health. Later it might be possible to refine it by introducing additional elements, such as different actors and areas of intervention. At this point, however, the Special Rapporteur begins by exploring a taxonomy of right to health good practices that is based upon right to health norms.

51. The Special Rapporteur's preliminary report outlines the right to health normative framework. For present purposes, three aspects of this framework require brief mention. First, the right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. Second, the right to health should be understood as a right to the enjoyment of a variety of facilities, goods and services necessary for the realization of the highest attainable standard of health. Third, health facilities, goods and services, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality.

52. Thus, a taxonomy based upon the right to health normative framework might classify initiatives in the nine categories set out below. After each category, one or two examples are given to illustrate possible right to health good practices — or elements of right to health good practices — that might exemplify that category. Of course, until the criteria for right to health good practices are settled, the examples are hypothetical: they are simply given to illustrate how the taxonomy of right to health good practices might work.

53. Thus, right to health good practices may be classified as initiatives that are consistent with all human rights, give particular attention to vulnerability, and which enhance:

(a) The *availability* of health facilities, goods and services within the jurisdiction (example: in appropriate cases, legislation for the grant of compulsory licences for essential medicines);

(b) The *accessibility without discrimination*, in law or fact, of health facilities, goods and services (example: the development and implementation of a comprehensive national strategy for promoting women's health throughout their life span);

(c) The *physical accessibility* of health facilities, goods and services (example: clean water in slums and remote rural areas; ramps to buildings for persons with physical disabilities);

(d) The *economic accessibility* of health facilities, goods and services (example: free medicines for under-fives; fee exemption schemes for those living in poverty);

(e) The *accessibility of health information* (example: poster campaigns to educate the public with accurate information about HIV/AIDS);

(f) The *cultural acceptability* of health facilities, goods and services (example: training programmes for health professionals on the culture of indigenous peoples living in the jurisdiction);

(g) The *quality* of health facilities, goods and services (example: testing for sub-standard, counterfeit or contaminated drugs);

(h) The *active and informed participation* of individuals and groups, especially the vulnerable and disadvantaged, including those living in poverty, in relation to health policies, programmes and projects (example: village meetings to consider local health priorities and budgets);

(i) Right to health *monitoring and accountability mechanisms* that are effective, transparent and accessible (example: health ombuds; health and human rights impact assessments).

Right to health good practices: specific examples?

54. The preceding paragraph provides hypothetical examples. However, the Special Rapporteur has begun to gather actual initiatives that may constitute right to health good practices. Three of these real examples are provided below — lack of space permits no more. Of course, until some of the conceptual issues signalled above are resolved, not least the criteria for identifying right to health good practices, it is premature to regard the following examples as right to health good practices. Moreover, the Special Rapporteur has not been able to obtain independent confirmation of all aspects of these practices.[13] Nonetheless, they are set out in the following paragraphs as examples of the sort of initiatives currently being undertaken that may prove to be — or contain elements of — right to health good practices.[14]

Colombia's mobile health brigades

55. The rural focus of the conflict in Colombia means that isolated communities often have difficulty accessing health care. Mobile health brigades, a project of the International Committee of the Red Cross (ICRC), the Colombian Red Cross, and

the Colombian Ministry of Health, have helped to promote the accessibility of health services, including to internally displaced people. Along the Caguán and Atrato rivers, ICRC "health boats" have reportedly reached isolated communities in conflict regions. By 1999, they had worked with more than 11,000 patients.[15]

56. Thus, this initiative may be an example of a right to health good practice that enhances the *availability* and *physical accessibility* of health facilities, goods and services.

The Brazilian National AIDS Programme

57. Free and universal access to antiretrovirals in the public health service, legally guaranteed by the Government of Brazil since 1996, has heightened the economic accessibility of these essential medicines, resulting in increasing numbers receiving treatment and a reduction in mortality in some areas.[16] The Government's strategy rests, on the one hand, on its decision to encourage domestic manufacture of antiretrovirals: by 2001, 63 per cent were manufactured domestically. On the other hand, the Government has sought to obtain those antiretroviral drugs that are purchased on the international market at the lowest possible prices, sometimes by referring to their willingness to issue a compulsory licence. In short, the Government has been prepared to utilize the flexibilities anticipated by the Agreement on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) and clarified by the Doha Declaration. Defending the right to treatment for HIV/AIDS has reportedly helped combat discrimination and stigmatization against people living with HIV/AIDS.[17]

58. Another important element of the Brazilian National Aids Programme is active civil society participation. Groups representing people living with HIV/AIDS, religious organizations and many others have reportedly been particularly active, for example, in advisory committees created to ensure the participation of civil society in the Programme.

59. Thus, the Programme may be an example of a right to health good practice that enhances the *availability* and *economic accessibility* of essential medicines, *active and informed participation* in health programmes, and *non-discrimination*.

The Constitution of South Africa and the Treatment Action Campaign *Case*

60. The South African Constitution recognizes the right of everyone to have access to public health-care services and the right of children to special protection. While the Government of South Africa identified nevirapine as its drug of choice for preventing mother-to-child transmission of HIV, it imposed restrictions on the availability of the drug in the public health sector. In *Minister for Health* v. *Treatment Action Campaign*, the Constitutional Court held that the Government was required "to devise and implement a comprehensive and coordinated programme to progressively realize the right of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV".[18] Further, the Court ordered the Government, inter alia, to make nevirapine available at public hospitals.

61. The Special Rapporteur understands that the Government is taking measures to implement the Court's judgement. Thus, the South African Constitution, *Treatment Action Campaign* case and the judgement of the Constitutional Court combined to

hold the authorities to account in relation to the right to health. The indispensable role of NGOs and the media in this process should be noted.

62. Thus, this experience may provide examples of right to health good practices that together establish an *accountability mechanism* in relation to the right to health.

Conclusion

63. The purpose of this section is modest: to begin to generate informed discussion about good practices and the right to health. Consistent with the request of the Commission on Human Rights, the Special Rapporteur has sought to provide an introductory overview of this complex topic. Clearly, the subject demands much more work. The Special Rapporteur aims to continue his research and hopes to deepen collaboration with relevant actors. He warmly encourages comments on the conceptual issues, and initiatives, that are outlined above. Further, he would very much welcome other examples of actual initiatives that may be right to health good practices.

IV. HIV/AIDS and the right to health

64. The scale of the HIV/AIDS pandemic and its impact on the human rights of those affected continue to dwarf global responses to these problems. Forty-two million people around the world now live with HIV while thousands die every day from AIDS. An effective global response requires a comprehensive approach that includes prevention, treatment, care and support, all of which are mutually reinforcing elements of a continuum.

65. For the purposes of this report, the Special Rapporteur wishes to highlight his particular concern about the continuing obstacles to ensuring access to treatment for HIV/AIDS — access being a fundamental component of the right to health. Some progress has been made and, in high-income countries, antiretroviral treatment is now widely available. At the international level, legal and political commitments have been made to improve access to essential drugs for all, particularly in the context of the TRIPS Agreement and the Declaration of Commitment on HIV/AIDS. Despite this, the situation remains urgent for developing countries, where treatment still reaches fewer than 5 per cent of those affected, as well as for many marginalized populations in high-income countries. For many people in developing countries, the cost of treatment remains impossibly high. At the same time, human rights violations, including discrimination faced by people living with or affected by HIV/AIDS, constitute a major barrier both to prevention efforts and access to treatment and care. The impact of HIV/AIDS on women is especially devastating.

66. In its resolution 2003/29, the Commission on Human Rights recognized that access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria is one fundamental element for achieving progressively the full realization of the right to health (para. 1). The Special Rapporteur stresses the urgent necessity of ensuring the availability and accessibility of treatment for all. The lives of those infected with HIV can be prolonged and their suffering relieved with appropriate care and treatment, including antiretroviral drugs. The use of antiretrovirals will significantly reduce the incidence of opportunistic infections and susceptibility to other major diseases, such as tuberculosis.[19] Particularly in areas where HIV accounts for up to 50 per cent of hospital admissions, the use of

antiretrovirals will ease the pressure on health systems by reducing morbidity and mortality and by relieving precious staff time and resources.[20]

67. Crucially, ensuring access to treatment will also have a positive impact on prevention efforts. The availability of treatment can reduce stigma and discrimination by reducing fear and enabling individuals, families and communities to openly address HIV and AIDS. Where treatment exists and is accessible to all of those who need it, individuals are more likely to seek voluntary testing and counselling. This will create a larger demand for voluntary testing and counselling services.[21] With the proper allocation of resources this, in turn, should ultimately lead to stronger health infrastructure. As WHO has stated, treatment should be seen not as an additional burden, but "as a powerful new driver, not only for the response to HIV/AIDS, but for the long-term sustainability of health systems overall".[22]

Declaration of Commitment on HIV/AIDS, human rights and accountability

68. The Declaration of Commitment on HIV/AIDS underscores that the full realization of human rights and fundamental freedoms for all, including the right to the highest attainable standard of health, is an essential element in the global response to the HIV/AIDS pandemic. The year 2003 marks the "due date" for several of the treatment and prevention goals and targets set by Member States in the Declaration, including the development of national strategies to strengthen health-care systems and address factors affecting the provision of HIV-related drugs. Member States have agreed to make "every effort to provide progressively and in a sustainable manner the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled antiretroviral therapy" (para. 55). In this connection, the Special Rapporteur welcomes recent efforts by WTO member States to ensure that the TRIPS Agreement is interpreted and implemented so as to protect public health and, in particular, to promote access to medicines for all. The Special Rapporteur encourages States to make use, and to respect the use by other States, of the full range of flexibilities contained in the TRIPS Agreement with a view to improving access to essential medicines in developing countries.

69. These political commitments reinforce the obligations of States under international human rights law with regard to treatment, care and prevention. The International Covenant on Economic, Social and Cultural Rights and other instruments commit States to ensure the right to the highest attainable standard of mental and physical health. This includes steps related to the treatment and control of epidemic diseases (art. 12.2 (c)), such as access to affordable HIV-related medications, and the creation of conditions which would ensure to all medical services and medical attention in the event of sickness (art. 12.2 (d)). The Convention on the Elimination of All Forms of Discrimination against Women provides, in article 12.1, that States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure access to health services. States parties to the Convention on the Rights of the Child recognize the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, and shall strive to ensure that no child is deprived of his or her right of access to such health-care services (art. 24).

70. Building on these human rights standards, the United Nations human rights system provides a means of ensuring accountability for HIV/AIDS-related human rights. The mandates given to the special procedures of the Commission on Human Rights — to examine, monitor and publicly report on human rights situations in specific countries or territories or on major phenomena of human rights violations worldwide — are an important tool for the protection and promotion of HIV-related rights. In the course of their work these special procedures can help strengthen respect for HIV/AIDS-related rights through their country missions, reports, urgent appeals and other advocacy work.

71. The Special Rapporteur proposes to look closely at HIV/AIDS issues, through the prism of the right to health, when he undertakes country missions. He will consider, for example, how States have approached the right to health-related goals identified in the Declaration of Commitment, as well as their national, regional and global responsibilities as set out in paragraphs 94-103 of the Declaration. The Special Rapporteur observes that United Nations human rights treaty bodies also provide an appropriate forum for States to be asked questions — and offered constructive advice — on the human rights dimensions of their HIV/AIDS policies and programmes, including their goals and responsibilities under the Declaration. In the opinion of the Special Rapporteur, one of the most distinctive contributions that international human rights law and procedures bring to the struggle against the HIV/AIDS pandemic is enhanced accountability.

OHCHR/UNAIDS meeting for Special Rapporteurs

72. In June 2003, UNAIDS and OHCHR jointly hosted a meeting of special rapporteurs and other Commission experts to develop a strategic approach for integrating HIV/AIDS-related issues into their work, with a view to strengthening country-level HIV/AIDS-related human rights activities. The participants were 16 special rapporteurs/representatives and independent experts (including country-specific mandate holders and thematic rapporteurs), as well as people living with HIV/AIDS, external resource persons, the Special Envoy of the Secretary-General on HIV/AIDS in Asia and people working at community level to combat the epidemic. The meeting provided an opportunity to discuss links between HIV/AIDS and human rights issues relevant to the mandates of the special procedures; it allowed the experts to exchange ideas and experiences on how best to address HIV/AIDS-related issues in the context of their work, drawing on good practice experiences.

73. The meeting underscored the importance of addressing difficult, cross-cutting human rights issues, including the factors that contribute to: HIV/AIDS-related vulnerabilities; stigma and discrimination (in relation to people living with HIV/AIDS, but also certain groups like injecting drug users, prisoners, sex workers, men who have sex with men); gender inequalities (including the need to combat sexual and economic exploitation of women and girls, including in conflict situations, and promote equality and non-discrimination in family, marriage, property, etc.); and access to prevention and treatment. Special rapporteurs noted the importance of working with existing networks and structures at country level, in particular United Nations Theme Groups on HIV/AIDS, United Nations country teams, UNAIDS and OHCHR field offices, networks of people living with HIV/AIDS, AIDS service organizations and other civil society groups.

74. Special Rapporteurs discussed and endorsed several practical steps that might be taken to address HIV/AIDS in the course of their work, including gathering information from UNAIDS and other relevant sources on the HIV/AIDS situation in-country, as well as existing activities and initiatives to combat the epidemic, in preparation for country missions; meeting with relevant government departments, national human rights institutions, people living with HIV/AIDS, civil society groups and AIDS service organizations to discuss HIV/AIDS-related issues during country missions; drawing the attention of the media to HIV/AIDS-related issues and, where appropriate, exposing AIDS-related human rights violations; providing recommendations on human rights issues related to HIV/AIDS to Governments, national human rights institutions, donors and international organizations; and following up on relevant recommendations and concluding observations made by treaty bodies.[23]

75. The Special Rapporteur congratulates UNAIDS and OHCHR for organizing this meeting which went beyond rhetorical statements to the formulation of practical recommendations for United Nations human rights experts, not all of whom were familiar with how they could best contribute to the HIV/AIDS response. For his part, the Special Rapporteur is ready to contribute to follow-up with the organizers as and when appropriate.

V. Neglected diseases, leprosy and the right to health

76. In his preliminary report, the Special Rapporteur observed that he wished to examine the right to health implications of neglected diseases and the "10/90 disequilibrium" — only 10 per cent of health research and development spending being directed at the health problems of 90 per cent of the world's population (para. 79). While there are different ways of defining neglected diseases, a recent WHO publication describes them as those diseases that "affect almost exclusively poor and powerless people living in rural parts of low-income countries".[24] In resolution 2003/28, the Commission on Human Rights requested the Special Rapporteur "to pursue his analysis of the issues of neglected diseases, including very neglected diseases" (para. 26).

77. Briefly, the Special Rapporteur has begun to address these issues in the following two ways. First, during his mission to WTO in July/August 2003, the Special Rapporteur had numerous informative and constructive meetings with, among others, members of the WTO secretariat, as well as ambassadors and other delegates to WTO. One of the many issues explored in these discussions was TRIPS and neglected diseases. In essence, intellectual property rights and related agreements — including the TRIPS Agreement — provide an incentive for health research and development where there is a market for a new drug, vaccine or other medical intervention. But, in the context of neglected diseases, there is no effective market and thus no effective incentive — and this contributes to the 10/90 gap. The Special Rapporteur used his mission to WTO to raise the profile of this serious human rights and humanitarian problem, and will report further to the next session of the Commission on Human Rights.

78. Second, the Special Rapporteur has met with the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR). TDR was created in 1975 largely in response to the failure of market forces to drive the

development of new drugs, vaccines and diagnostic tools for diseases causing a heavy burden in tropical countries. In short, TDR was a pioneering response to the highly distorted health research agenda. Working within a modest budget, the Programme has produced an impressive stream of practical tools for making progress against the 10 diseases in its mandate. At present, TDR and the Special Rapporteur are considering whether it might be possible to identify a limited project that would provide a right to health analysis of the general problem of neglected diseases and the 10/90 disequilibrium.

79. In this context, the Special Rapporteur highlights a related issue. One of the 10 diseases within the mandate of TDR is leprosy — a disease that has afflicted humanity since time immemorial. In the last few years, enormous strides — too numerous to mention here — have been taken towards the elimination of leprosy. Nonetheless, leprosy remains a serious public health problem, especially (but not exclusively) in the developing countries of Asia and Africa. The disease is closely linked to poverty. Every year 600,000 new cases are diagnosed.[25] Untreated, leprosy causes immense physical suffering and disability. But the disease has another punishing dimension. People affected by leprosy — including patients, former patients and their families — often suffer stigma and discrimination born of ignorance and prejudice. Today, it is estimated that tens of millions of people are unfairly and irrationally treated on account of leprosy.[26]

80. In these circumstances, the Special Rapporteur suggests that it would be instructive to devise a right to health approach to the elimination of leprosy, including the stigma and discrimination associated with the disease. Such an initiative could draw upon the rich experience of human rights and HIV/AIDS, as well as recent work on human rights and tuberculosis.[27] Building on these experiences, a right to health and leprosy initiative could serve, conceivably, as a model for wider application. It could also provide a human rights contribution to the Global Alliance for the Elimination of Leprosy, a WHO initiative that was established in 1999 to unite key players in the struggle against the disease. The Special Rapporteur would welcome comments and advice on the tentative suggestion that it is timely to devise a right to health approach to leprosy.

VI. An optional protocol to the International Covenant on Economic, Social and Cultural Rights

81. In its resolution 2003/18 the Commission invited all special rapporteurs whose mandates deal with the realization of economic, social and cultural rights to share their views on an optional protocol to the International Covenant on Economic, Social and Cultural Rights and to make recommendations thereon (para. 15) to the working group on an optional protocol.

82. In response to this invitation, the Special Rapporteur makes the following observations which draw upon the views he expressed at the International Conference on Economic, Social and Cultural Rights held in Cavtat, Croatia, in September 2003. The Conference was hosted by the Government of Croatia and co-organized by Croatia and the International Commission on Jurists, with financial support from the Government of Finland. Participants included member States of the Council of Europe, NGOs and independent experts. In the opinion of the Special

Rapporteur, the Conference provided a constructive, balanced and extremely useful overview of the issues which the working group will probably wish to consider.

83. While national laws and policies often neglect people living in poverty because of their marginal place in society, an optional protocol to the Covenant can help to ensure that those living in poverty receive due attention. The promotion and protection of economic, social and cultural rights demands a variety of legal and non-legal initiatives, but a key legal component of any multidimensional strategy for economic, social and cultural rights should be an optional protocol. The Special Rapporteur suggests that, like the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, an optional protocol to the Covenant should provide for both a complaints and an inquiry procedure. As his preliminary report showed, domestic and regional laws and cases confirm the justiciability of the right to health and elements of the right to health (paras. 10-20). The Special Rapporteur does not regard justiciability as a significant obstacle to the adoption of an optional protocol and warmly endorses the proposal as an important mechanism for the better promotion and protection of the right to health.

84. The Special Rapporteur suggests that OHCHR might be asked to prepare some brief studies to inform the working group's deliberations. For instance, it could collect a selection of national case law on economic, social and cultural rights. The working group might also find instructive a short study on the economic, social and cultural rights jurisprudence arising from one or more of the regional human rights procedures and institutions.

VII. Concluding remarks

85. Some components of a right to health strategy demand new concepts and tools. This interim report has begun to explore some of these conceptual challenges, such as possible right to health indicators and good practices. As observed in the Introduction, this conceptual work is valuable — provided that, in due course, it leads to improvements in health status and greater respect for the fundamental human right to health, especially of those living in poverty. Crucially, all those with responsibilities in relation to the right to health must not lose sight of the alarming facts intimated in paragraph 3 above. Properly understood and deployed, the right to health can dignify people, empower communities, galvanize action, catalyse change, shape policies and lead to improvements in people's health.

Notes

[1] For example, the Special Rapporteur has participated in several meetings and workshops organized by WHO; a workshop on the right to health organized by Médecins Sans Frontières (Belgium); a conference on economic, social and cultural rights organized by the Government of Croatia and the International Commission of Jurists; and a panel discussion on access to health care of poor people at the fifty-sixth World Health Assembly organized by WHO and Save the Children (UK). He also participated in the annual meeting of special rapporteurs organized by OHCHR, an OHCHR/UNAIDS meeting for special rapporteurs on HIV/AIDS, and a meeting with the UNAIDS Global Reference Group on HIV/AIDS and Human Rights.

[2] *Human Development Report 2003: Millennium Development Goals: A compact among nations to end human poverty*, UNDP, pp. 8-9.

[3] *Human Development Report 2000: Human Rights and Human Development*, UNDP, p. 89.

[4] Ibid.

[5] See *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies*, OHCHR, www.unhchr.ch/development/povertyfinal.html, 2002, para. 37.

[6] While this is the point of departure, strategies have to be contextualized and prioritized. Vulnerability, stigma and discrimination vary in different contexts. Thus, in a particular context, there may be a case for giving priority to the collection of some disaggregated data rather than others. But, from the human rights perspective, the goal remains: to use right to health indicators that are disaggregated in relation to as many of the internationally prohibited grounds of discrimination as possible.

[7] *Indicators for Monitoring National Drug Policies: A Practical Manual*, WHO, 1999.

[8] Respectively, paras. 57-58 and 53-54.

[9] The examples are drawn from *Reproductive Health Indicators for Global Monitoring: Report of the Second Interagency Meeting*, WHO, 2001, and *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators*, UNAIDS, 2002.

[10] Ibid.

[11] See *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators*, UNAIDS, 2002.

[12] Generally, see *Best Practices in Poverty Reduction: An Analytical Framework*, Else Øyen (ed.), CROP and Zed Books, 2002.

[13] For example, as indicated in paragraph 12, for a health good practice to be a right to health good practice, the process by which it is formulated must be consistent with all human rights. This means, inter alia, identifying the various duty bearers and clarifying why the practice is most appropriate in the particular context. The Special Rapporteur has not been able to confirm all these procedural and other aspects in relation to the examples given.

[14] While it will not be repeated on each occasion, it should be understood that the three examples are possible illustrations of either right to health good practices or *elements* of right to health good practices.

[15] See *Growing the Sheltering Tree: Protecting Rights Through Humanitarian Action*, UNICEF/Inter-Agency Standing Committee, 2002, p. 118.

[16] See J. Galvão, *Access to Anti-Retroviral Drugs in Brazil, Lancet*, vol. 360, 7 December 2002, p. 1682.

[17] Ibid.

[18] Constitutional Court of South Africa, case CCT 8/02, para. 135 (2) (a).

[19] A *commitment to action for expanded access to HIV/AIDS treatment*, International HIV Treatment Access Coalition, WHO, December 2002, p. 5.

[20] Report on the Global HIV/AIDS Epidemic, UNAIDS, July 2002.

[21] *A commitment to action*, op. cit., p. 4.

[22] Ibid.

[23] Report on the Joint UNAIDS and OHCHR Discussion on HIV/AIDS and Human Rights, 30 June 2003, forthcoming.

[24] *Global Defence against the Infectious Disease Threat*, WHO, 2002, p. 96.

[25] "*Leprosy and human rights*", presentation by Yohei Sasakawa, WHO Special Ambassador for the Elimination of Leprosy, during the fifty-fifth session of the Sub-Commission on the Promotion and Protection of Human Rights, 4 August 2003.

[26] Ibid.

[27] *A Human Rights Approach to Tuberculosis*, WHO, 2001.